New Jersey Department of Health and Senior Services
Office of Provider Enrollment
PO Box 367
Trenton, NJ 08625-0367

PROVIDER APPLICATION

1. Legal Name of Provider	2. Type of Business of Facility
3. Business Name, if Different from Above	4. Federal Employer ID Number / SSN
5. Street Address of Service Location Only	6. County
7. City State Zip Code	8. Length of Time at Address

9. Billing Address (for payments)

10. Mailing Address (for correspondence)

11. Name of Nursing Home Administrator, Chief Executive Officer or Other Responsible Official

12a. Nursing Home Administrator License No.	12b. Effective Date	13. Telephone Number

14. Indicate the legal status of your organization:

☐ Profit ☐ Private ☐ Municipal ☐ Charity ☐ County
☐ Non-Profit ☐ Public ☐ State ☐ School Nurse ☐ Other, Specify:

15. List the specific service(s) for which you are requesting approval for reimbursement under the Medicaid Program:

16. Do you operate from more than one location?

☐ Yes ☐ No If yes, list all other subsidiary or affiliated organizations below:

Name	Service Address
1. _____	_____
2. _____	_____
3. _____	_____

(Attach additional sheets if necessary.)

17. Are you a member of a chain organization?

☐ Yes ☐ No

If yes, indicate name: _____

18. Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health and Senior Services?

☐ Yes ☐ No

If yes, attach a copy of the Certificate of Need. If no, explain why you do not require a certificate.

19. Does your business or facility require a license/permit?

☐ Yes ☐ No

If yes, indicate type and number: _____

Attach a copy of the license/permit.

20. Do you require certification, accreditation or approval?

☐ Yes ☐ No

If yes, specify type: _____

Attach a copy of the certification, accreditation or approval.

For example, New Jersey Department of Health and Senior Services (clinics); State Board of Dentistry (dental clinics); State Board of Pharmacy (providers offering pharmaceutical services).

Legal Name of Provider	Federal Employer ID Number / SSN

21. Approved by Medicare?

☐Yes ☐No

If yes, indicate Medicare Provider Number: _____

Attach a copy of your Medicare approval.

22. Are you currently or have you ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction?

☐Yes ☐No

If yes, list types of services provided and current status. If you were approved at one time and you no longer participate, explain the reason(s).

23. Have any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the individuals named in response to Question 11 ever been the subject of any license suspension, revocation, or other adverse licensure action in this state or any other jurisdiction?

☐Yes ☐No

If yes, explain.

24. Have any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the individuals named in response to Question 11 ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime in this state or any other jurisdiction?

☐Yes ☐No

If yes, explain.

25. Have any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the individuals named in response to Question 11 ever been the subject of any Medicaid (Title XIX) or Medicare (Title XVIII) suspension, debarment, disqualification or recovery action in this state or any other jurisdiction?

☐Yes ☐No

If yes, explain.

PROVIDER APPLICATION, Continued

Legal Name of Provider	Federal Employer ID Number / SSN

26. Do any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the other individuals named in response to Question 11 own or have any financial interest in any other provider participating in the New Jersey Medicaid (Title XIX) Program or the Medicaid Program of any other state or jurisdiction?

☐Yes ☐No

If yes, list provider name and nature of relationship.

27. Do you charge for goods and/or services?

☐To All ☐To None ☐To Certain Groups Only

If you charge to all or only certain groups, please explain your arrangement and attach a copy of your fee schedule.

28. List days and hours of operation.

29. List the Name(s), Social Security Number(s), Date(s) of Birth, License/Permit Number(s) and Title(s) or Degree(s) for all professional staff in the organization. Include physicians, dentists, psychologists, pharmacists, registered nurses, licensed practical nurses, registered physical therapists, optometrists, etc. [NOTE: Not required for health care providers certified for Medicaid and/or Medicare participation by the New Jersey Department of Health and Senior Services and/or the Centers for Medicare and Medicaid Services (CMS), formerly known as Health Care Financing Administration (HCFA).]

	Name	Title/Degree (MD, DO, Ph.D, CPO, etc.)	SSN	Date of Birth	License Permit No.
1.					
2.					
3.					
4.					
5.					
6.					
7.					

(Attach additional sheets if necessary.)

CERTIFICATION

For the purpose of establishing eligibility to receive direct payment for services to recipients under the New Jersey Medicaid (Title XIX) Program, I certify that the information furnished on this application is true, accurate, and complete. I am aware that if any of the statements made by me on this application are willfully false, I am subject to punishment, including but not limited to suspension, debarment or disqualification from the New Jersey Medicaid Program in accordance with N.J.A.C. 10:49-1.17(d)22. I agree to notify the New Jersey Department of Health and Senior Services, Office of Provider Enrollment, at least quarterly, of all future additions to any of those named in Questions 23 - 26, for whom the response to those same questions would be affirmative.

Name of Provider Representative	Title

Signature	Date

FOR STATE USE ONLY

☐Approve ☐Disapprove ☐Other **Initial**_____ **Date**_____

Provider Type(s)	**Category of Service**	**Specialty**